Florida Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1172096	(X2) MULTIPLE CONSTRUCTION A. BUILDING 05 - MAIN LIC B. WING	(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER: GLADES HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 230 SOUTH BARFIELD HIGHWAY , PAHOKEE, Florida, 33476	

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K0000 Bldg. 05	INITIAL COMMENTS An unannounced Fire & Life Safety re-licensure survey was conducted on at Glades Health Care Center, a nursing home in Pahokee, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2021 Edition) and applicable requirements of Florida State Fire Marshal's Rules and Regulations, Florida Administrative Code (F.A.C) 69A-3, F.A.C. 69A-53, F.A.C. 59A-4, and Florida Statutes (F.S.) 400 Part II, and F.S. 633.0215, adopting National Fire Protection Association (NFPA) 1 and 101 (2021 Edition) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2. The following is a description of the deficiencies found at the time of the visit.	K0000		
K0291 SS = F Bldg. 05	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least /2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview the facility failed to comply in accordance with NFPA 101 2021. Battery lighting testing of at least 90 minutes must be provided. This deficiency could affect all occupants in the facility in case of a fire or other emergency. The findings included: During record review on between the hours of 9:15 AM and 1:30 PM with the Maintenance Director, the facility failed to provide documentation that the annual 90 minutes testing of the battery lighting was performed. The Maintenance Director acknowledged that the facility failed to provide documentation that the	K0291	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law. The 90 minute battery lighting test was completed and documentation is placed in the maintenance director book. The facility has determined that all residents have the potential to be affected. An in-service education program will be conducted by the administrator. The administrator will conduct for three months random checks of completed documentation.	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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K0291 SS = F Bldg. 05	Continued from page 1 annual 90 minutes testing of the battery lighting was performed. NFPA 101 2021 19.2.9.1 Class III	K0291		
K0345 SS = F Bldg. 05	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance Detection systems, where required, shall be in accordance with Section 9.6. Fire alarm systems required by this Code shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA70 and NFPA72 unless otherwise permitted by 9.6.1.4. 18.3.4.1, 19.3.4.1, 9.6, and NFPA 70, and NFPA 72 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview the facility failed to comply in accordance with NFPA 101 2021. A log book must be provided at the Fire Panel signed by the vendor upon completion of work provided. Smoke detector sensitivity testing biennially. Fire Alarm Design Systems located at the Fire Panel This deficiency could affect all occupants in the facility in case of a fire or other emergency. The findings included: 1.During record review on between the hours of 9:15 AM and 1:30 PM with the Maintenance Director, the facility failed to provide a log book at the Fire Panel signed by the vendor with the work completed each visit. The Maintenance Director acknowledged that the facility failed to provide a log book at the Fire Panel signed by the vendor with the work completed each visit. 2.During record review on between the hours of 9:15 AM and 1:30 PM with the Maintenance Director, the facility failed to provide documentation that the biennial sensitivity testing on the smoke detector was performed. The Maintenance Director acknowledged the facility	K0345	The fire alarm book was placed at the fire panel with the pull station zones and building map. (Fire Alarm System Design Plan) This was completed on The biennial sensitivity testing on the smoke detectors was completed on The facility has determined that all residents have the potential to be affected. An in-service education program will be conducted by the administrator. The administrator will conduct for a period of three months a random audit of completed documentation.	

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K0345 SS = F Bldg. 05	Continued from page 2 failed to provide documentation that the biennial sensitivity testing on the smoke detector was performed. 3.During record review on between the hours of 9:15 AM and 1:30 PM with the Maintenance Director, the facility failed to provide the Fire Alarm System Design Plans at the Fire Panel. The Maintenance Director acknowledged the facility failed to provide the Fire Alarm System Design Plans at the Fire Panel. NFPA 101 2021 9.6.5,9.6.7, NFPA 72 Class III	K0345		
K0353 SS = F Bldg. 05	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25. All required documentation regarding the design of the fire protection system and the procedures for maintenance, inspection, and testing of the fire protection system shall be maintained at an approved, secured location for the life of the fire protection system. 19.7.6, 4.6.12, 4.6.12.1, 9.11 through 9.11.3.2, and NFPA 25 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview the facility failed to comply in accordance with NFPA 101 2021. Must complete annually a flow test on the fire hydrant and a 5 year gallons per minute testing. Five year riser inspection and a five year hydrostatic testing of the FDC (Fire Department Connection) This deficiency could affect all occupants in the facility in case of a fire or other emergency. The findings included: 1. During record review on between the hours of 9:15 AM and 1:30 PM with the Maintenance Director, the facility failed to provide documentation	K0353	The five year gallon per minute testing was completed on , , . The five year internal inspection was performed on the riser on , , . The five year hydrostatic testing was performed and completed on , , . The five year gallon per minute testing on the fire hydrant was completed on , , . The facility has determined that all residents have the potential to be affected. An in-service education program will be conducted by the administrator. The administrator will conduct for a period of three months a random audit of completed documentation.	

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K0353 SS = F Bldg. 05	Continued from page 3 that the annual flow test was performed on the fire hydrant. The Maintenance Director acknowledged that the facility failed to provide documentation that the annual flow test was performed on the fire hydrant. 2. During record review on between the hours of 9:15 AM and 1:30 PM with the Maintenance Director, the facility failed to provide documentation that the five-year gallons per minute testing was performed on the fire hydrant. The Maintenance Director acknowledged the facility failed to provide documentation that the five-year gallons per minute testing was performed on the fire hydrant. During record review on between the hours of 9:15 AM and 1:30 PM with the Maintenance Director, the facility failed to provide documentation that the five-year internal inspection was performed on the fire riser. The Maintenance Director acknowledged the facility failed to provide documentation that the facility failed to provide documentation that the five-year internal inspection was performed on the fire riser. During record review on between the hours of 9:15 AM and 1:30 PM with the Maintenance Director, the facility failed to provide documentation that the five-year hydrostatic testing was performed on the FDC (Fire Department Connection) The Maintenance Director acknowledged the facility failed to provide documentation that the five-year hydrostatic testing was performed on the FDC (Fire Department Connection). NFPA 101 2021 9.6.5,9.6.7, NFPA 72 Class III	K0353		
K0712 SS = F Bldg. 05	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills in health care occupancies shall include the simulation of emergency fire conditions and,	K0712	Facility conducted fire drills on all three shifts. These drills were done on , , , , and , . The facility has determined that all residents have the potential to be affected.	

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K0712 SS = F Bldg. 05	Continued from page 4 except as indicated in 18/19.7.1.7, include activation of the fire alarm system notification appliances. Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. and 6:00 a.m. (2100 hours and 0600 hours), a coded announcement shall be permitted to be used instead of activating the fire alarm system notification appliances. Employees of health care occupancies shall be instructed in life safety procedures and devices. 18.7.1.4 through 18.7.1.8, 19.7.1.4 through 19.7.1.8 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview the facility failed to comply in accordance with NFPA 101 2021. The facility must have a fire drill each shift per quarter. This deficiency could affect all occupants in the facility in case of a fire or other emergency. The findings included: During record review on between the hours of 9:15 AM and 1:30 PM with the Maintenance Director, the facility failed to provide documentation that the fire drills were performed. Fire drills missing first quarter 2026 third shift and second and third shifts of the last quarter of 2025. The Maintenance Director acknowledged that the facility failed to provide documentation that the fire drills were performed. Fire drills missing first quarter 2026 third shift and second and third shifts of the last quarter of 2025. NFPA 2021 19.7.1 Class III	K0712	Continued from page 4 An in-service education program will be conducted by the administrator. The administrator will conduct for a period of three months a random audit of completed documentation.	

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K0914 SS = F Bldg. 05	Electrical Systems - Maintenance and Testing CFR(s): NFPA 99 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep or general is administered, are tested after initial installation, replacement, or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.3.3.2, which activates both visual and audible alarm (see 6.3.2.9.3.2). For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.3 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.3.2 (NFPA 99) This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview the facility failed to comply in accordance with NFPA 99 2021. The facility must ensure of receptacle testing annually for tension and polarity. This deficiency could affect all occupants in the facility in case of a fire or other emergency. The findings included: During record review on between the hours of 9:15 AM and 1:30 PM with the Maintenance Director the facility failed to provide documentation that the receptacle testing for tension and polarity was performed annually. The Maintenance Director acknowledged that the facility failed to provide documentation that the facility failed to provide documentation that the receptacle testing for tension and polarity was performed anually. NFPA 99 2021 6.3.4 Class III	K0914	The Tension and Polarity test was performed throughout the building and completed on The facility has determined that all residents have the potential to be affected. An in-service education program will be conducted by the administrator. The administrator will conduct for a period of three months a random audit of completed documentation.	

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K0918 SS = F Bldg. 05	Electrical Systems - Essential Electric Syste CFR(s): NFPA 99 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40-day intervals, and exercised once every 36 months for four continuous hours. Scheduled test under load conditions includes a complete simulated start and automatic or manual transfer of all EES loads and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.9.1, 6.9.2, 6.9.3, 6.9.4, 6.10.18, 6.11 through 6.11.4.4 (NFPA 99), NFPA 110, NFPA 111, NFPA 70 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview the facility failed to comply in accordance with NFPA 99 2021. Main & Feeder Breaker exercise annually per manufacturers recommendations. This deficiency could affect all occupants in the facility in case of a fire or other emergency. The findings included: During record review on between the hours of 9:15 AM and 1:30 PM with the Maintenance Director, the facility failed to provide documentation that the main & feeder breakers were exercised according to manufactures recommendations.	K0918	A generator load test was performed on . Documentation of work performed is in the record book and print out from machine is also on . The facility has determined that all residents have the potential to be affected. An in-service education program will be conducted by the administrator. The administrator will conduct for a period of three months a random audit of completed documentation.	

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K0918 SS = F Bldg. 05	Continued from page 7 The Maintenance Director acknowledged that the facility failed to provide documentation that the facility failed to provide documentation that the main & feeder breakers were exercised according to manufactures recommendations. . NFPA 99 2021 6.4.4, 6.5.4,6.6.4 Class III	K0918		
K0921 SS = F Bldg. 05	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 99 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 (NFPA 99) This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview the facility failed to comply in accordance with NFPA 99 2021. Testing and maintenance of electrical equipment for patient care. This deficiency could affect all occupants in the facility in case of a fire or other emergency.	K0921	The testing of electrical equipment was performed by DESCO throughout the building. A report has been provided and work was completed on , , The facility has determined that all residents have the potential to be affected. An in-service education program will be conducted by the administrator. The administrator will conduct for a period of three months a random audit of completed documentation.	

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K0921 SS = F Bldg. 05	Continued from page 8 The findings included: During record review on between the hours of 9:15 AM and 1:30 PM with the Maintenance Director the facility failed to provide documentation that the electrical testing on equipment used for patient care was completed annually. The Maintenance Director acknowledged that the facility failed to provide documentation that the electrical testing on equipment used for patient care was completed annually. NFPA 99 2021 10.3,10.5.2.1, 10.5.2.5 Class III	K0921		
K0923 SS = F Bldg. 05	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 99 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic Storage locations are designed, constructed, and in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 (5 if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum hr. fire protection rating. Less than or equal to 300 cubic In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of	K0923	tank cylinders were removed from certain locations and the number of tanks were reduced in those locations. The tanks were relocated to a locked designated area. This was completed on The facility has determined that all residents have the potential to be affected. An in-service education program will be conducted by the administrator. The administrator will conduct for a period of three months a random audit of completed documentation.	

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K0923 SS = F Bldg. 05	Continued from page 9 which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid . Cylinders stored in the open are protected from weather. 11.3, 11.3.5 through 11.3.12.5, 11.6.5 (NFPA 99) This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interview the facility failed to comply in accordance with NFPA 99 2021. storage of more than 12 "E" tanks in a sprinkler room must not be stored within five of combustibles. This deficiency could affect all occupants in the facility in case of a fire or other emergency. The findings included: During observations on at 4:30 PM with the Maintenance Director it was noted that 18 "E" tags of were being stored in a sprinkler room, within five of combustibles. The Maintenance Director acknowledged that 18 "E" tags of were being stored in a sprinkler room, within five of combustibles. NFPA 99 2021 11.3.1, 11.3.2,11.3.3 Class III	K0923		
K1006 SS = F Bldg. 05	Considerations not Related to Fire CFR(s): NFPA 101, FAC 59A-4.130 The Code also addresses other considerations that, while important in fire conditions, provide an ongoing benefit in other conditions of use, including non-fire emergencies. NFPA 101 (2021) 101 1.1.5. 59A-4.130 Fire Prevention, Fire Protection, and Life Safety, Systems Failure and External Emergency Communications. (1) Each nursing home licensee must provide fire protection through the elimination of fire hazards as	K1006	The facility placed itself on a self imposed fire watch due to the red tags given to us from our sprinkler system vendor. The fire watch started on , , and is still on-going pending the final report from our vendor. The facility notified the local area office of AHCA and the Fire Marshall of the Palm Beach Fire Rescue. The facility notified both parties on , . Daily logs are being sent to the AHCA surveyor and the fire Marshall. The facility has determined that all residents have the potential to be affected. An in-service education program will be conducted by the administrator.	

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K1006 SS = F Bldg. 05	Continued from page 10 evidenced by compliance with the fire codes adopted by the State Fire Marshall. The fire codes adopted by the State Fire Marshal for nursing homes is contained Rule Chapter 69A-53, F.A.C., and is known as "Uniform Fire Safety Standards for Hospitals and Nursing Homes." (2) All fires or explosions shall be reported to the Agency's Office of Plans and Construction by telephone at (850)412-4477 or by fax at (850)922-6483 by the next working day after the occurrence. The nursing home licensee shall complete and submit a Fire Incident Report, AHCA form 3500-0031, , incorporated by reference and available at http://www.flrules.org/Gateway/reference.asp?No=Ref-06023, to the Office of Plans and Construction and a copy to the appropriate Agency field office within 15 calendar days of the incident. All reports shall be complete and thorough and shall record the cause of the fire or explosion, the date and time of day it occurred, the location within the facility, how it was extinguished, any injuries which may have occurred and a description of the local fire department participation. The Fire Incident Report is available from the Agency for Health Care Administration, Office of Plans and Construction, 2727 Mahan Drive, Mail Stop #24, Tallahassee, Florida 32308 or at the web address: http://ahca.myflorida.com/plansandconstruction. (3) If a system failure of the fire alarm system, smoke detection system, or sprinkler system occurs, the following actions shall be taken by the licensee: (a) Immediately notify the local fire department and document the response and any instructions given by the local fire department. (b) Notify the Agency's Office of Plans and Construction and the appropriate Agency field office within one business day after the occurrence. (c) Assess the extent of the condition, effect corrective action and document the estimated length of time for the corrective action. If the corrective action will take more than four hours, the following must be completed: 1. Implement a contingency plan to the facility fire plan containing a description of the problem, a specific description of the system failure, and the projected correction period. All staff on the shifts involved must have documented in-service training for the emergency contingency.	K1006	Continued from page 10 The administrator will conduct for a period of three months a random audit of completed documentation.	

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NAME OF PROVIDER OR SUPPLIER GLADES HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 230 SOUTH BARFIELD HIGHWAY , PAHOKEE, Florida, 33476	

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K1006 SS = F Bldg. 05	Continued from page 11 2. Begin a documented fire watch until the system is restored. Staff performing the fire watch must be trained in appropriate observations and actions, as well as be able to expeditiously contact the fire department. To maintain a fire watch, the licensee must utilize only certified public fire safety personnel, a security guard service, or facility staff. If facility staff are used for this function, they must meet the following criteria: a. Be off duty from their regular facility position or assigned only to fire watch duty. The licensee must maintain compliance with direct care staffing requirements at all times; b. Be trained and competent, as determined by the licensee, in the duties and responsibilities of a fire watch; c. Have immediate access to two-way electronic communication. 3. If the projected correction period changes or the system is restored to normal operation, the licensee must notify the appropriate Agency's field office and local fire authorities. (4) External Emergency Communication. Each newly constructed facility that has not received a Preliminary Plan Approval from the Office of Plans and Construction by , shall provide for external electronic communication not dependent on terrestrial telephone lines, cellular, radio, or microwave towers, such as an on-site radio transmitter, satellite communication systems or a written agreement with an amateur radio operator volunteer group. This agreement must provide for a volunteer operator and communication equipment to be relocated into the facility in the event of a disaster until communications are restored. Other methods that can be shown to maintain uninterrupted electronic communications not dependent on a land-based transmission must be approved by the Agency's Office of Plans and Construction. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview the facility failed to comply in accordance with 59A-4.130. The facility must provide fire protection through the elimination of fire hazards. Sprinkler systems must be in working order. This deficiency could affect all occupants in the facility in case of a fire or other emergency.	K1006		

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K1006 SS = F Bldg. 05	Continued from page 12 The findings included: During record review on between the hours of 9:15 AM and 1:30 PM with the Maintenance Director, the facility failed to provide documentation that the Fire Riser was maintained in proper working order. Three red tags from the sprinkler vendor were observed since of 2025. The facility failed to notify the authority having jurisdiction (Agency for Healthcare Administration and Palm Beach County Fire Rescue). The facility failed to implement a Fire Watch until repairs were made. The Maintenance Director and the Administrator acknowledged that the facility failed to notify the authority having jurisdiction (Agency for Healthcare Administration and Palm Beach County Fire Rescue). The facility failed to implement a Fire Watch until repairs were made. 59-A-4.130 Class III	K1006		
K1051 SS = F Bldg. 05	Plans Submittal PRIOR to Work CFR(s): FAC 59A-4.134( ), FBC (2023) 8th Ed 45 (1) No construction work, including demolition, shall be started until prior written approval has been provided by the Agency's Office of Plans and Construction. This includes all construction of new facilities and all additions, modifications, alterations, renovations, and refurbishing to the site, facility, equipment or systems of all existing facilities. (2) Approval to start construction only for demolition, site work, foundation, and building structural frame may be obtained prior to construction document approval when the following is submitted for review and approval: (a) Preliminary approval letter from the Agency's Office of Plans and Construction. (b) Construction documents and specifications for all work to be undertaken. (c) A life safety plan indicating temporary egress and detailed phasing plans indicating how the areas to be demolished or constructed are to be separated from all occupied areas when demolition or construction is in and around occupied buildings. (3) Projects that have been submitted to the Agency	K1051	The following resident room numbers 24, 25, 28, and 30 have been decommissioned and have been taken out of service until the generator is relocated. The four rooms will remain out of service until the project is complete and deemed in compliance by AHCA. A submission for the relocation of the generator will be sent to the Office of Plans and Construction for a full plan review. This submission to the OPC will occur no later than , . Upon approval of the project from OPC with an issued project number, the relocation of the generator will immediately be initiated. The facility has determined that all residents have the potential to be affected. An in-service education will be conducted by the administrator. The administrator will conduct a three month review of all necessary paperwork for relocation paperwork.	

Florida Agency for Health Care Administration

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K1051 SS = F Bldg. 05	Continued from page 13 for review will be considered abandoned and will be terminated after any of the following has occurred: (a) Construction has not begun within one year after written approval of the construction documents from the Agency's Office of Plans and Construction; (b) No further plans have been submitted for Agency review within one year after a project has been initiated with the Agency's Office of Plans and Construction; (c) Construction has been halted for more than one year. After termination, resubmission as a new project will be required. (4) When construction is planned, either for new buildings, additions, alterations or renovations to existing buildings, the plans and specifications must be prepared and submitted to the Agency's Office of Plans and Construction for approval by a Florida registered architect and a Florida registered professional engineer. An architecture or engineering firm, not practicing as a sole proprietor, must provide proof of registration as an architecture or engineering firm with the Florida Department of Business and Professional Regulation. Florida Administrative Code 59A-4.134(1)-(4) & Florida Building Code (2023) 8th edition Section 450.1. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview the facility failed to comply in accordance with 59A-4.134. The facility must submit plans to Office of Plans and Construction before construction. This deficiency could affect all occupants in the facility in case of a fire or other emergency. The findings included: During record review on between the hours of 9:15 AM and 1:30 PM with the Maintenance Director and the Administrator the facility failed to provide documentation that the four rooms identified, , , and 30 will never be used as patient rooms due to the fact that a 250 KW generator was installed outside, directly in front of these rooms. This is due to not submitting plans to the Office of Plan and Construction before installing the generator. The Maintenance Director and the Administrator	K1051		

Florida Agency for Health Care Administration

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K1051 SS = F Bldg. 05	Continued from page 14 acknowledged the facility failed to provide documentation that the four rooms identified , , and 30 will never be used as patient rooms due to the fact that a 250 KW generator was installed outside, directly in front of these rooms. 59A-4.134 FBC (2020) Class III	K1051		
K1053 SS = F Bldg. 05	Emergency Management Plan CFR(s): FAC 59A-4.126 A written, comprehensive emergency management plan for emergency care during an internal or external disaster or emergency, which is ... shall be maintained. The health care facility shall test the implementation of the emergency management plan semiannually, either in response to a disaster or an emergency or in a planned drill, and shall evaluate and document the health care facility performance to the health care facility safety committee. Florida Administrative Code 59A-4.126. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview the facility failed to comply in accordance with 59A-4.126. The facility shall test the implementation of the emergency management plan semiannually. This deficiency could affect all occupants in the facility in case of a fire or other emergency. The findings included: During record review on between the hours of 9:15 AM and 1:30 PM with the Maintenance Director and the Administrator, the facility failed to provide documentation that the semiannual testing of the emergency management plan was performed. The Maintenance Director and the Administrator acknowledged the facility failed to provide documentation that the semiannual testing of the emergency management plan was performed. 59A-4.126 Class III	K1053	The facility ran in-service drill for internal and external drills. Paperwork is in the log book in the maintenance director's books. The facility has determined that all residents have the potential to be affected. An in-service education program will be conducted. The administrator will conduct a three month check to verify completion of documentation.	

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K1150 SS = F Bldg. 05	Security Management CFR(s): NFPA 99 (2021 Edition) This chapter shall apply to new and existing health care facilities. A health care facility shall have a security management plan. The scope, objectives, performance, and effectiveness of the security plan shall be tested at a frequency shown to be necessary by review of the security vulnerability assessment (SVA) in accordance with Section 13.3. NFPA 99 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview in accordance with the facility failed to comply in accordance with NFPA 99 2021. The facility must ensure the Security Vulnerability Assessment must be updated and reviewed each year. This deficiency could affect all occupants in the facility in case of a fire or other emergency. The findings included: During record review on between the hours of 9:15 AM and 1:30 PM with the Maintenance Director and the Administrator, the facility failed to provide documentation that the Security Vulnerability Assessment was updated and reviewed each year. The Maintenance Director and the Administrator acknowledged the facility failed to provide documentation that the Security Vulnerability Assessment was updated and reviewed each year. NFPA 99 2021 13.3 Class III	K1150	Security vulnerability assessment was reviewed and a signature page was placed in the binder. The facility has determined that all residents have the potential to be affected. An in-service education program will be conducted by the administrator. The administrator will conduct a three month check to verify completion of documentation.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106018	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN FED B. WING	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER: GLADES HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 230 SOUTH BARFIELD HIGHWAY , PAHOKEE, Florida, 33476	

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K0000 Bldg. 01	INITIAL COMMENTS An unannounced Fire & Life Safety Recertification survey was conducted on at Glades Health Care Center, a nursing home in Pahokee, Florida. Glades Health Care Center is not in compliance with 42 CFR 483 Subpart B, 42 CFR 488.307, and National Fire Protection Association (NFPA) 101 (2012 Edition), NFPA 99 (2012 Edition) requirements for nursing homes. Initial Plan Review: 1983 Existing NFPA 220 Construction Type: III (000) Number of beds: 120 Census: 51 The following is a description of the noncompliance.	K0000		
K0291 SS = F Bldg. 01	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least /2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: Based on record review and staff interview the facility failed to comply in accordance with NFPA 101 2012. Battery lighting testing of at least 90 minutes must be provided. This deficiency could affect all occupants in the facility in case of a fire or other emergency. The findings included: During record review on between the hours	K0291	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State law. The 90 minute battery lighting test was completed and documentation is placed in the maintenance director book The facility has determined that all residents have the potential to be affected. An in-service education program will be conducted by the administrator. The administrator will conduct monthly random	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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K0291 SS = F Bldg. 01	Continued from page 1 of 9:15 AM and 1:30 PM with the Maintenance Director, the facility failed to provide documentation that the annual 90 minutes testing of the battery lighting was performed. The Maintenance Director acknowledged that the facility failed to provide documentation that the annual 90 minutes testing of the battery lighting was performed. NFPA 101 2012 19.2.9.1	K0291	Continued from page 1 checks to verify completed documentation.	
K0345 SS = F Bldg. 01	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on record review and staff interview the facility failed to comply in accordance with NFPA 101 2012. A log book must be provided at the Fire Panel signed by the vendor upon completion of work provided. Smoke detector sensitivity testing biennially. Fire Alarm Design Systems located at the Fire Panel This deficiency could affect all occupants in the facility in case of a fire or other emergency. The findings included: 1. During record review on between the hours of 9:15 AM and 1:30 PM with the Maintenance Director, the facility failed to provide a log book at the Fire Panel signed by the vendor with the work completed each visit. The Maintenance Director acknowledged that the facility failed to provide a log book at the Fire Panel signed by the vendor with the work completed each visit. 2. During record review on between the hours of 9:15 AM and 1:30 PM with the Maintenance Director, the facility failed to provide documentation	K0345	The fire alarm book was placed at the fire panel with the pull station zones and building map. (Fire Alarm System Design Plan) This was completed on The biennial sensitivity testing on the smoke detectors was completed on The facility has determined that all residents have the potential to be affected. An in-service education program will be conducted by the administrator. The administrator will conduct for a period of three months a random audit of completed documentation.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K0345 SS = F Bldg. 01	Continued from page 2 that the biennial sensitivity testing on the smoke detector was performed. The Maintenance Director acknowledged the facility failed to provide documentation that the biennial sensitivity testing on the smoke detector was performed. 3. During record review on between the hours of 9:15 AM and 1:30 PM with the Maintenance Director, the facility failed to provide the Fire Alarm System Design Plans at the Fire Panel. The Maintenance Director acknowledged the facility failed to provide the Fire Alarm System Design Plans at the Fire Panel. NFPA 101 2021 9.6.5,9.6.7, NFPA 72	K0345		
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked ________________ b) Who provided system test ________________ c) Water system supply source ________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on record review and staff interview the facility failed to comply in accordance with NFPA 101	K0353	The five year gallon per minute testing was completed on , . The five year internal inspection was performed on the riser on , . The five year hydrostatic testing was performed and completed on , . The five year gallon per minute testing on the fire hydrant was completed on , . The facility has determined that all residents have the potential to be affected. An in-service education program will be conducted by the administrator. The administrator will conduct for a period of three months a random audit of completed documentation.	

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K0353 SS = F Bldg. 01	Continued from page 3 2012. Must complete annually a flow test on the fire hydrant and a 5-year gallons per minute testing. Five-year riser inspection and a five-year hydrostatic testing of the FDC (Fire Department Connection). This deficiency could affect all occupants in the facility in case of a fire or other emergency. The findings included: 1. During record review on between the hours of 9:15 AM and 1:30 PM with the Maintenance Director, the facility failed to provide documentation that the annual flow test was performed on the fire hydrant. The Maintenance Director acknowledged that the facility failed to provide documentation that the annual flow test was performed on the fire hydrant. 2. During record review on between the hours of 9:15 AM and 1:30 PM with the Maintenance Director, the facility failed to provide documentation that the five-year gallons per minute testing was performed on the fire hydrant. The Maintenance Director acknowledged the facility failed to provide documentation that the five-year gallons per minute testing was performed on the fire hydrant. During record review on between the hours of 9:15 AM and 1:30 PM with the Maintenance Director, the facility failed to provide documentation that the five-year internal inspection was performed on the fire riser. The Maintenance Director acknowledged the facility failed to provide documentation that the facility failed to provide documentation that the five-year internal inspection was performed on the fire riser. During record review on between the hours of 9:15 AM and 1:30 PM with the Maintenance Director, the facility failed to provide documentation that the five-year hydrostatic testing was performed on the FDC (Fire Department Connection) The Maintenance Director acknowledged the facility failed to provide documentation that the five-year hydrostatic testing was performed on the FDC (Fire Department Connection). NFPA 101 2021 9.6.5,9.6.7,	K0353		

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K0353 SS = F Bldg. 01	Continued from page 4 NFPA 72	K0353		
K0712 SS = F Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on record review and staff interview the facility failed to comply in accordance with NFPA 101 2012. The facility must have a fire drill each shift per quarter. This deficiency could affect all occupants in the facility in case of a fire or other emergency. The findings included: During record review on between the hours of 9:15 AM and 1:30 PM with the Maintenance Director, the facility failed to provide documentation that the fire drills were performed. Fire drills missing first quarter 2026 third shift and second and third shifts of the last quarter of 2025. The Maintenance Director acknowledged that the facility failed to provide documentation that the fire drills were performed. Fire drills missing first quarter 2026 third shift and second and third shifts of the last quarter of 2025. NFPA 2012 19.7.1	K0712	Facility conducted fire drills on all three shifts. These drills were done on , , , , and , . The facility has determined that all residents have the potential to be affected. An in-service education program will be conducted by the administrator. The administrator will conduct for a period of three months a random audit of completed documentation.	
K0914 SS = F Bldg. 01	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep or general is	K0914	The Tension and Polarity test was performed throughout the building and completed on , , . The facility has determined that all residents have the potential to be affected.	

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NAME OF PROVIDER OR SUPPLIER **GLADES HEALTH CARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP CODE **230 SOUTH BARFIELD HIGHWAY , PAHOKEE, Florida, 33476**	

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K0914 SS = F Bldg. 01	Continued from page 5 administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on record review and staff interview the facility failed to comply in accordance with NFPA 99 2012. The facility must ensure of receptacle testing annually for tension and polarity. This deficiency could affect all occupants in the facility in case of a fire or other emergency. The findings included: During record review on between the hours of 9:15 AM and 1:30 PM with the Maintenance Director the facility failed to provide documentation that the receptacle testing for tension and polarity was performed annually. The Maintenance Director acknowledged that the facility failed to provide documentation that the facility failed to provide documentation that the receptacle testing for tension and polarity was performed annually. NFPA 99 2012 6.3.4	K0914	Continued from page 5 An in-service education program will be conducted by the administrator. The administrator will conduct for a period of three months a random audit of completed documentation.	
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying	K0918	A generator load test was performed on , , . Documentation of work performed is in the record book, and print out from machine is also on . The facility has determined that all residents have the potential to be affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **106018**	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN FED** B. WING	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER **GLADES HEALTH CARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP CODE **230 SOUTH BARFIELD HIGHWAY , PAHOKEE, Florida, 33476**	

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K0918 SS = F Bldg. 01	Continued from page 6 service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on record review and staff interview the facility failed to in accordance with comply in accordance with NFPA 99 2012 Main & Feeder Breaker exercise annually per manufacturers recommendations. This deficiency could affect all occupants in the facility in case of a fire or other emergency. The findings included: During record review on between the hours of 9:15 AM and 1:30 PM with the Maintenance Director, the facility failed to provide documentation that the main & feeder breakers were exercised according to manufactures recommendations. The Maintenance Director acknowledged that the facility failed to provide documentation that the main & feeder breakers were exercised according to manufactures recommendations. . NFPA 99 2012 6.4.4, 6.5.4,6.6.4	K0918	Continued from page 6 An in-service education program will be conducted by the administrator. The administrator will conduct for a period of three months a random audit of completed documentation.	

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K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on record review and staff interview the facility failed to comply in accordance with NFPA 99 2012. Testing and maintenance of electrical equipment for patient care. This deficiency could affect all occupants in the facility in case of a fire or other emergency. The findings included: During record review on between the hours of 9:15 AM and 1:30 PM with the Maintenance Director the facility failed to provide documentation that the electrical testing on equipment used for patient care is completed annually. The Maintenance Director acknowledged that the facility failed to provide documentation that the electrical testing on equipment used for patient care is completed annually. NFPA 99 2012	K0921	The testing of electrical equipment was performed by DESCO throughout the building. A report has been provided and work was completed on The facility has determined that all residents have the potential to be affected. An in-service education program will be conducted by the administrator. The administrator will conduct for a period of three months a random audit of completed documentation.	

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K0921 SS = F Bldg. 01	Continued from page 8 10.3,10.5.2.1, 10.5.2.5	K0921		
K0923 SS = F Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic Storage locations are designed, constructed, and in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 (5 if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum hr. fire protection rating. Less than or equal to 300 cubic In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid . Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview the facility failed to comply in accordance with NFPA 99 2012. storage of more than 12 "E" tanks in a	K0923	tank cylinders were removed from certain locations and the number of tanks were reduced in those locations. The tanks were relocated to a locked designated area. This was completed on The facility has determined that all residents have the potential to be affected. An in-service education program will be conducted by the administrator. The administrator will conduct for a period of three months a random audit of completed documentation.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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K0923 SS = F Bldg. 01	Continued from page 9 sprinkler room must not be stored within five of combustibles. This deficiency could affect all occupants in the facility in case of a fire or other emergency. The findings included: During observations on at 4:30 PM with the Maintenance Director, it was noted that 18 "E" tags of were being stored in a sprinkler room, within five of combustibles. The Maintenance Director acknowledged that 18 "E" tags of were being stored in a sprinkler room, within five of combustibles. NFPA 99 2012 11.3.1, 11.3.2,11.3.3	K0923		

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E0000	Initial Comments During the Fire & Life Safety Recertification survey, conducted on at Glades Health Care Center, a nursing home, Emergency Preparedness was reviewed. Glades Health Care Center is not in compliance with Emergency Preparedness per Code of Federal Regulations (CFR) 42, Part 483.73, Requirement for Long-Term Care Facilities.	E0000		
E0004 SS = F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.	E0004	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law. Facility EP was reviewed and signed off on by the DON, Maintenance Director and Administrator. The facility has determined that all residents have the potential to be affected. An in-service education program will be conducted by the administrator. The administrator will conduct monthly random checks to verify completed documentation.	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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E0004 SS = F	Continued from page 1 * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For Facilities at §494.62(a):] Emergency Plan. The facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is NOT MET as evidenced by: Based on facility record review and interview with the Administrator, the facility failed to provide the annual review and update of their Emergency Preparedness Program (EP). Annual review and updating of the program is required to address the changing environments of the community, the facility and the facility populations. The findings included: On at 4:00 PM, while reviewing the facility's EP, no evidence of annual updates and review by the facility administration was found. the Administrator acknowledged that the Emergency Management Plan had not been reviewed or updated. Per 42 CFR 483.73(a)	E0004		